CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
PRE-ENROLLMENT APPLICATION

Instructions to the Parent or Patient

- In order to receive a health examination today at no charge, you must provide the information required on this form. The information you give is confidential. This is a voluntary program (Title 17, California Code of Regulations, Sections 6802 and 6832).
- Filling out and signing this form may provide you or your child with a complete health exam today and may provide dental, vision, mental, and other health services at no cost for this month and next month.

Is the patient less than 19 years of age? ☐ Yes ☐ No

How many people are in your family? _____

How much money does your family make before taxes? $_____ (Monthly) Or $_____ (Yearly)

- You or your child may be eligible for continued health care coverage through Medi-Cal or Healthy Families. If you answer NO to this question, the patient's coverage for health, dental, and vision benefits will stop the end of next month. You will still be eligible for CHDP preventive services.

I want to apply for continuing coverage through Medi-Cal or Healtlhy Families. ☐ Yes ☐ No

Patient Information

Does the patient have a State of California Benefits Identification Card (BIC) or Medi-Cal card? ☐ Yes ☐ No

If yes, what is the identification number on the BIC card (if available)? _____

Patient's name—Last	First	Middle

Date of birth (month/day/year)	Gender
	☐ Male ☐ Female

☐ If you are homeless, check here. Enter the general location in the "Home address" section and complete the "Mailing address" section.

Home address	Apartment number	City	State	ZIP code

County of residence

Mailing address (if different from home address)	Apartment number	City	State	ZIP code

Patient's social security number ***(optional)***	Mother's name—Last	First

Parent/Legal Guardian Information

Name of parent/legal guardian or emancipated minor patient—Last	First	Middle

Home telephone number	Work telephone number	Message telephone number
( )	( )	( )

What language do you speak at home?	read best?

Certification

I am requesting a CHDP health examination today. I certify that I have read and understand this form. I declare that the information I have provided is true, correct, and complete.

Signature of parent/guardian or emancipated minor	Relationship to patient	Date

An individual has a right to review records containing his/her personal information. The official responsible for keeping this information is the Department of Health Services, P.O. Box 942732, Sacramento, CA 94234-7320. A copy of this information will also be kept with your child's medical record.